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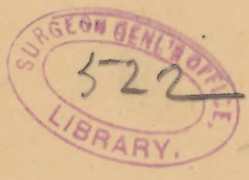

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ABDOMINAL HYSTEROPEXY.*

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Next to pelvic inflammation there is, perhaps, no other disease that we are more commonly called upon to treat than retrodisplacements.

After confinement the ligaments are lax, the uterus heavy and enlarged, and softer than when in a healthy condition, so that should there be any excessive intra-abdominal pressure, or, as too often happens, the woman may be kept on her back after labor and perhaps a large pad and too tight abdominal binder applied, the condition of retroversion is confirmed.

Then, again, the pressure acting on the anterior instead of the posterior surface of a softened uterus may cause the fundus to flex on the cervix, and we have retroflexion.

There almost always follows from this condition symptoms of endometritis and pelvic peritonitis, constant pain in the back, pain while menstruating, and often a too excessive flow, while sterility is pretty certain to exist; or if pregnancy should occur, there is the almost certainty of abortion.

It is to the treatment of these troublesome cases and their permanent relief that I wish to draw your attention. Most of the authorities, except those of the last year or two, advise that these cases should be treated by massage to loosen adhesions if they are present, and after replacing the uterus to depend on the artificial support of pessaries. The trouble in obtaining an instrument that will properly retain the uterus without causing pain, the tendency to irritation and even ulceration from pressure or want of cleanliness while wearing a pessary, besides the inconvenience, have called for some way of retaining the uterus in its normal position by operative means.

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The two operations which have been found of benefit are shortening of the round ligaments and abdominal hysteropexy.

The former operation is limited to those cases where the uterus is freely movable and where there are no adhesions; but the difficulty in finding the round ligament; the chance of mistaking something else for it; the danger of tearing the ligament, especially when in advancing age it has undergone fatty degeneration; and lastly, the limited experience of most men—render this operation of very infrequent application.

Baldy says: "It is a question whether that operation alone could afford much relief. It is usually preceded and followed by measures which insure its success, and which possibly might have succeeded without the Alexander operation. Again, the operation has a small rate of mortality and a too high rate of failure. It occupies a position between plastic work, which has failed in its purpose, and cœliotomy." It is limited to those cases where there are "no adhesions, no endometritis, and no tubal or ovarian disease; but the uterus maintains a retroposition, which still gives rise to symptoms. These, and only these, are the cases for Alexander's operation. They must be exceedingly rare, for if a retroposed uterus is put into a healthy condition, the pelvic flow restored, and the organ supported for some months, its ligaments will regain their tone and require no shortening."

Several attempts have been made to fasten the uterus to the vagina, or, as the operation is called, colpohysteropexy; but they are all open to the objection of acting on the fundus and fixing the uterus to tissues that are movable and extensible.

The other operation, then, or abdominal hysteropexy, presents a means of retaining the uterus permanently in a natural position, relieving the painful symptoms due to and kept up by the displacement, and often curing the dysmenorrhœa and sterility which so urgently call for relief.

Like many other surgical procedures, this operation was suggested by accident, for so long ago as 1869, in a case of retroflexion causing symptoms of intestinal obstruction, Kœberlé opened the abdomen and removed a healthy ovary, suturing the pedicle to the lower part of the wound and thus curing the displacement. Between this time and 1880 several cases of a somewhat similar kind were recorded by Schröder, Lawson Tait, and Hennig.

Shortly after this Olshausen recorded an original method, and this has been variously improved upon by Czerny, Klotz, and Howard Kelly.

The latter has recently published an account of forty-five cases without a single death, and showing remarkably good results.

The operation as now perfected is done as follows: The pubis is shaved and the abdominal wall thoroughly prepared by washing and antisepsis. The Trendelenburg posture is preferable. An incision scarcely more than two inches in length is made through the skin and sheath of the rectus, the muscle being separated by the fingers; the peritoneum is exposed and incised between catch forceps A stitch is then taken on each side of the wound, fastening the peritoneum to the skin, thus facilitating the next step in the operation and preventing subsequent invagination of the peritoneum. The uterus is lifted up, freed from adhesions, if present, and held in an anteflexed position while the ovaries and tubes are examined, and, if diseased, they are treated according to the condition found. A curved needle armed with silkworm gut is passed under and through the peritoneum and subperitoneal tissue, transverse to the incision, about half an inch away from its edge and close to the symphysis pubis. It is then passed through the posterior surface of the uterus, just below the fundus, taking in a layer of tissue half an inch in width and about an eighth of an inch in thickness. The suture is then passed through the other side of the incision. Another suture is passed about a quarter of an inch lower down on the posterior uterine tissue; the uterine surface which is to be approximated to the peritoneal surface is gently scarified; the sutures are tied and cut short.

The abdominal wound is then closed either by continuous catgut sutures, taking up each layer separately, or by silkworm gut through all the tissues together.

Antiseptic dressings and a binder are applied. There is usually very little bleeding from the uterine sutures, and the operation is hardly any more dangerous than an uncomplicated cœliotomy.

It is not necessary to use a Hodge pessary afterward, nor to tampon the vagina. Sänger, Routier, and Kelly have all recorded cases where abdominal hysteropexy has been performed that afterward became pregnant and were safely delivered without damage to the supporting adhesions.

This operation, then, seems to meet the indications for a procedure which will relieve those cases of otherwise incurable retroflexion, and where the intensity of the symptoms demand some means of permanent relief.